Chapter 3 -- Enrollment and Disenrollment Policies (OPL99.100)

Section 2.0 -- Eligibility for Enrollment in M+C Plans

In general, an individual is eligible to elect a M+C plan when all of the following requirements are met. More specific detail regarding these requirements follows.

1. The individual is entitled to Part A and enrolled in Part B, provided that he or she will be entitled to Medicare Part A and Part B as of the effective date of coverage under the plan (see exceptions described under section 2.6); and,
2. The individual has not been medically determined to have ESRD prior to completing the enrollment form (see exceptions described under section 2.2); and,
3. The individual permanently resides in the service area of the M+C plan. In the case of individuals ("age-ins") who are enrolled in a health plan offered by the M+CO, the individual may reside in either the M+C plan's service area or the M+CO's continuation area; and,
4. The individual or his/her representative signs an enrollment form that is complete and includes all the information required to process the enrollment; and,
5. The individual is fully informed of and agrees to abide by the rules of the M+CO that were provided during the election process; and,
6. The individual makes the election during an election period, as described in section 3.

A M+C plan must accept any individual (permanently residing in the M+C plan service area or M+CO continuation area) who is enrolled in a health plan offered by the M+CO the month immediately preceding the month in which the individual is entitled to Medicare Part A and Part B. In this case, the M+C plan must accept the individual even if s/he has ESRD. The individual must meet all other M+C eligibility requirements.

A M+CO must not deny enrollment to otherwise eligible individuals who continue to work and to be enrolled in their employer's health benefits plan, or that of their spouse. If the individual enrolls in a M+C plan and continues to be enrolled in his/her employer's health benefits plan, or that of his/her spouse, then coordination of benefits rules apply. Refer to Chapter 5 for more information.

A M+C eligible individual may not be enrolled in more than one M+C plan at any given time. Procedures for handling multiple transactions, cancellations, and reinstatements are described under section 7.

2.1 -- Entitlement to Medicare Parts A and B

An individual may elect a M+C plan when s/he is entitled to Part A and enrolled in Part B, provided that he or she will be entitled to Medicare Part A and Part B as of the effective date of coverage under the plan (exceptions for Part B-only members are outlined in section 2.6).

A M+CO may continue to offer Part A-equivalent coverage to Part B-only Grand fathered members, as described in section 2.6. However, a M+CO may not offer Part A-equivalent coverage to individuals enrolled only in Part B (and not entitled to Part A) in order to make them "eligible" for enrollment. Eligibility requirements are met based on Part A entitlement through Medicare and not through the purchase of Part A-equivalent benefits through the M+CO. The M+CO may refer the individual to Social Security if the individual wishes to enroll in Part A in order to be eligible to enroll in the M+C plan.

While desirable, it is not necessary for an individual to prove Part A entitlement or Part B enrollment at the time s/he signs the enrollment form. However, the enrollment form is not considered complete until the M+CO can verify such entitlement or enrollment through the individual or other available means (refer to section 4.1 and 4.1.1 for more information).

2.2 -- End Stage Renal Disease

An individual is not eligible to elect a M+C plan if he or she has been medically determined to have ESRD as defined in 42 CFR 406.13(b), which states "End-stage renal disease means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life."

An individual who elects a M+C plan and who is medically determined to have ESRD after the signature date on the enrollment form but before the effective date of coverage under the plan is still eligible to elect the plan.

An individual who develops ESRD while enrolled in a M+C plan may continue to be enrolled in the M+C plan. Once enrolled in the M+C plan, the member may elect other M+C plans in the same M+CO (during allowable election periods, as described under section 3.0). However, the member would not be eligible to elect a M+C plan in a different M+CO.

An age-in who develops ESRD while a member of a health plan offered by a M+CO, and who permanently resides in a M+C plan service area or M+CO continuation area for that same M+CO, may elect the M+C plan if other eligibility requirements are met. This individual must have been enrolled in the other health plan the month before these requirements are met, and the M+CO must accept the election.

The M+CO is permitted to ask at the time of the election whether the applicant has ESRD. This question is not considered health screening since the law does not permit a person with ESRD to elect a M+CO, except as provided in the previous paragraphs. A M+CO must deny enrollment to any individual medically determined to have ESRD,

except as provided in the previous paragraphs. HCFA will reject the enrollment if Medicare records indicate the applicant has ESRD as defined above.

2.3 -- Permanent Residence in Service or Continuation Area

An individual is eligible to elect a M+C plan if he or she permanently resides in the service area of the M+C plan. A temporary move into the M+C plan's service area does not enable the individual to elect the M+C plan; the M+CO must deny such an election.

A member who permanently moves from the service area of the M+C plan to an approved continuation area of the M+CO, and who chooses the continuation of enrollment option offered by the M+CO, may continue to be enrolled in the M+C plan (refer to section 7.7 for more detail on the requirements for the continuation of enrollment option).

Individuals (age-ins) who reside in the continuation area of a M+CO while a member of a health plan offered by the same M+CO may elect a M+C plan in that same M+CO when other eligibility requirements are met. These individuals must have been enrolled in the other health plan the month before these requirements are met, and the M+CO must accept the election.

Individuals who do not live in the service area of the M+C plan, or the continuation area of the M+CO as permitted above, may not elect the M+C plan. The M+CO must deny enrollment to these individuals.

Proof of permanent residence is normally established by the address of an individual's residence, but a M+CO may request additional information such as voter's registration records, driver's license records, tax records, and utility bills. Such records must establish the permanent residence address, and not the mailing address, of the individual.

2.4 -- Completion of Enrollment Form

An eligible individual can elect a M+C plan only if he or she completes and signs an enrollment form, provides required information to the M+CO within required time frames, and submits the properly completed form to the M+CO for enrollment. Model enrollment forms are included in Exhibits 1, 2, and 3. An individual who is a member of a M+C plan and who wishes to elect another M+C plan in the same M+CO must complete a new enrollment form to enroll in the new M+C plan; however, that individual may use an abbreviated enrollment form (refer to Exhibit 3 for a model abbreviated enrollment form) to make the election in place of the comprehensive individual enrollment form.

A M+CO must deny enrollment to any individual who does not properly complete the enrollment form within required time frames. Procedures for completing the enrollment form are provided in sections 4.1 and 4.1.1. Refer to section 1.0 for a definition of "receipt of election" and "completed election form."

2.5 -- Agreeing to Abide By M+CO Rules

An individual is eligible to elect a M+C plan if he or she is fully informed of and agrees to abide by the rules of the M+CO that were provided during the enrollment process (refer to section 4.2 regarding what information must be provided to the individual during the enrollment process). "Fully informed" means that the individual must be provided with the applicable rules of the M+CO, as described in section 4.2. The M+CO must deny enrollment to any individual who does not agree to abide by the rules of the M+CO.

2.6 -- Grand fathering of Members on January 1, 1999

Any individual who was enrolled in a § 1876 risk plan effective December 1, 1998 or earlier and remained enrolled with the risk plan on December 31, 1998 automatically continued to be enrolled in the M+CO on January 1, 1999, even if s/he was not entitled to Part A or did not live in a M+C plan service area or M+CO continuation area. The M+CO may not automatically disenroll these individuals because they are not entitled to Part A or do not live in the service or continuation area. However, if these individuals elect to disenroll from the M+CO, they will not be eligible to enroll in any M+C plan until or unless they meet all M+C eligibility requirements.

In addition, Part B-only Grand fathered members may continue to be enrolled in the M+CO on January 1, 1999 even if they are not entitled to Part A and did not purchase the Part A-equivalent coverage from the risk plan. These members may continue as members of the M+CO and are entitled to receive and have payment made for Part B services. These members may not be automatically disenrolled by the M+CO and must be notified annually of their status, as described below. If enrollment in Part B ends for an individual, the individual may not continue as a member of the M+C plan , and must be disenrolled as described in sections 5.2.2 and 5.6.

The M+CO must identify all Part B-only "Grand fathered" individuals and inform them of their status annually. The notice must inform these individuals that if they disenroll from the M+CO, they cannot elect another M+C plan unless they become entitled to Part A (by enrolling in Part A at SSA and by paying the appropriate premium to HCFA) and remain enrolled in Part B.

M+COs may continue to provide Part A-equivalent benefits to Part B-only Grand fathered members. In addition, if a M+CO offers Part A-equivalent coverage as a supplemental benefit in a M+C plan, then the M+CO may disenroll a Part B-only Grand fathered member who fails to pay the organization's Part A-equivalent premium, just as any member of the M+CO could be disenrolled for non-payment of premiums (refer to 42 CFR 422.74(b) and section 5.3.1).

Grand fathered members may enroll in other M+C plans in the same M+CO. However, if the Part B-only or ESRD Grand fathered members disenroll from the M+CO (i.e., they switch to original Medicare), they will not be eligible to enroll in any M+C plan in any M+CO until or unless they meet all M+C eligibility requirements, including but not

limited to, that of being entitled to Medicare Part A and not having ESRD. If the out-of-area Grand fathered members disenroll from the M+CO (i.e., they switch to original Medicare or attempt to enroll in another M+CO), they will only be able to enroll in other M+COs if they meet all M+C eligibility requirements, including, but not limited to, that of living in the service area of the M+C plan.

2.7 -- Eligibility and the Hospice Benefit

A M+CO must not deny enrollment to any individual who has elected the hospice benefit. Until the M+CO acknowledges that it has received the completed enrollment form and gives a coverage effective date to the individual (refer to Exhibit 4 and section 4), the M+CO must not ask any questions related to the existence of a terminal illness or election of the hospice benefit. Such questions will be considered health screening, and are not permitted.

The M+CO may not disenroll any member solely on the basis of the member electing the hospice benefit either before or after becoming a member of the M+C plan. Instead, the M+CO must provide, or continue to provide, services unrelated to the terminal condition, including any additional benefits provided for in the M+C plan. If the member chooses to revoke the hospice election, the M+CO again becomes responsible for providing all covered services and benefits included in the M+C plan. Refer to Chapter 4 for an explanation of special payment provisions for hospice members.

2.8 -- Continuation of Enrollment Option

With HCFA approval, a M+CO may establish continuation areas, separate and apart from a M+C plan's service area. Refer to Chapter 8 regarding HCFA approval of continuation areas. As defined in section 1.0, the HCFA-approved continuation area is an additional area outside a M+C plan's service area within which the M+CO furnishes or arranges for furnishing of services to the M+C plan's members. Members may only choose to continue enrollment with the M+C plan if they have permanently moved out of the M+C plan's service area and into the continuation area.

If a member does not choose the continuation of enrollment option when s/he is eligible for the option, then the individual is no longer eligible to be a member of the M+C plan, and the M+CO must initiate the individual's disenrollment. Procedures for continued enrollment are in section 7.7 and procedures describing disenrollment for permanent change of residence are described in section 5.2.1.

As described in Chapter 5, if an M+CO wants to offer a continuation of enrollment option, then it must obtain HCFA's approval of the continuation area and the marketing materials that describe the continuation of enrollment option. The M+CO must also describe the enrollment option(s) in member materials and make the option available to all members who make a permanent move to the continuation area. A M+CO may require members to give advance notice of their intent to use the continuation of enrollment option. If the M+CO has this requirement, then it must fully describe the required

notification process in the HCFA-approved marketing materials. In addition, the M+CO must fully explain any continuation option to all potential members of the M+C plan, current members of any other health plan of the M+CO and current risk and/or M+C members who reside in the M+C plan service area and/or M+CO continuation area.

2.9 -- Additional Eligibility Requirements for M+C Religious Fraternal Benefit (RFB) Plans

A M+C RFB plan is a plan that a RFB society may offer only to members of the church, or convention or group of churches with which the society is affiliated. The requirement for membership can be met by any documentation establishing membership issued by the church, or by using the church's records of membership. An individual must also meet all the other requirements to elect a M+C plan.

2.10 -- Eligibility Requirements for Medicare MSA Plans

Although an individual may meet all the requirements to elect a M+C plan, there are additional requirements and limitations on the individuals who may wish to elect Medicare MSA plans. An individual is not eligible to elect an Medicare MSA plan if any one of the following applies:

- The number of individuals enrolled in Medicare MSA plans has reached 390,000; or,
- The individual will reside in the United States for fewer than 183 days during the year in which the election is effective; or,
- Initial enrollment is on or after January 1, 2003 (i.e., no new enrollees may be accepted beginning January 1, 2003. Individuals whose enrollment is already in effect on January 1, 2003, including those who elected a Medicare MSA for a January 1, 2003 effective date, may remain members of that Medicare MSA after January 1, 2003); or
- The individual is enrolled in a Federal Employee Health Benefit plan, or is eligible for health care benefits through the Department of Veterans Affairs or the Department of Defense; or,
- The individual is entitled to coverage of Medicare cost-sharing under a Medicaid State plan; or,
- The individual is receiving hospice benefits prior to completing the enrollment form; or,
- The individual receives health benefits that cover all or part of the annual Medicare MSA deductible such as through insurance primary to Medicare, supplemental insurance policies not specifically permitted under 42 CFR 422.104, or retirement health benefits.